

Hawaii was the first state to provide for abortion essentially at the request of the woman. This is a report on the experience during the first months under the new law and a discussion of some related medical and statistical problems.

ABORTION IN HAWAII: THE FIRST 124 DAYS

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Introduction

ON March 13, 1970, Hawaii changed its 100-year-old law on abortion and became the first state in the nation to allow abortion essentially at the request of the woman. The new Hawaii law makes abortion legal if it is performed by a licensed physician in an accredited hospital, if performed before the fetus is viable outside the uterus, and on a woman who has been a resident for 90 days or more immediately prior to the abortion. The only restrictions imposed are those similar to any other medical hospital procedure.

Prior to the passage of the law, many legislators, individuals, and organizations expressed concern about the effects of the new law. Due to these, the state legislature allocated funds to the University of Hawaii School of Public Health to study the problem. A wide-ranging study of pregnancy, birth control, and abortion was initiated. The present paper is the first report under this study, conducted through the auspices of the University of Hawaii College of Health Sciences and Social Welfare, School of Public Health, and School of Medicine, with the Department of Sociology. In addition to the subject of this report, future papers will report on demographic features of the women involved, the relationship of atti-

tudes, sexual behavior practices, and the use of contraception to the decision-making process involved in the initiation or interruption of a pregnancy.

Methods

Data were collected on abortion patients and a control sample of maternity patients from hospital charts, self-administered questionnaires, and indepth interviews. These three instruments provide extensive information on the medical, demographic, socioeconomic, psychosocial, and attitudinal aspects of legal abortion within the broader context of pregnancy and alternative outcomes—i.e., the decision of whether to continue a pregnancy or have an abortion.

This paper will report on initial data from abortion patients only and from two of the three instruments—hospital charts and the self-administered questionnaire. Hospital charts on all abortion patients have been made available to the study by virtually every hospital in the state that is performing abortions. Information from the charts includes demographic, medical, and socioeconomic data, as well as method of payment. Data from hospital charts from March 13, 1970—the date of the first abortions under the new law—through July 15, 1970, are included in this report.

The self-administered questionnaire was given to abortion patients when they were admitted and was filled out by each patient prior to abortion. Participation by all patients was voluntary. The questionnaire provides information on demographic, socioeconomic and attitudinal data, aspirations of family size, contraceptive usage, reasons for nonuse of contraceptives, and reasons for either having the abortion or having the baby. The questionnaire data reported here are from abortion patients at two large facilities in Honolulu (hospitals #1 and #2) during the period from June 1 to July 15, 1970. Information was also obtained by interviews and correspondence with hospital administrators, medical personnel, and physicians.

Results (Medical)

A. Overview

Throughout the state of Hawaii, from March 13, 1970, through July 15, 1970, a total of 1,192 abortions were performed. The following data are based on 1,169 of them which represents 98.8

per cent* of the total. The geographic distribution of the abortions does not follow the population distribution within the state. Out of the ten hospitals performing abortions, nine are participating in this study (Figure 1).

A total of 1,136 (97.1%) abortions were performed on Oahu. Three hospitals in Honolulu performed 96.1 per cent of the state's abortions (Table 1).

* 1.2 per cent (23) of the abortions were performed in one small rural hospital which chose not to participate in the study.

Table 1—Induced abortions by hospital, Hawaii: 3/13/70-7/15/70

Hospital	No.	%
1	134	11.5
2	737	63.0
3	12	1.0
4	253	21.6
5*	33	2.8
Total	1,169	99.9

* Conglomerate representing six hospitals on the outer islands.

Figure 1—Distribution of induced abortions in Hawaii, 3/13/70 to 7/15/70

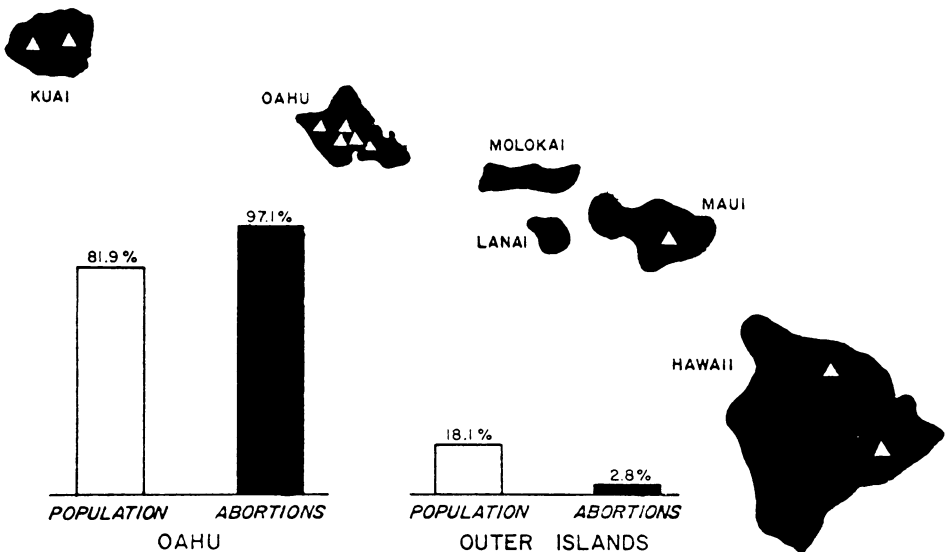


Table 2—Procedures used to induce abortions

Type	%	No.
D&C	30.8	360
D&C and suction	56.8	664
Subtotals	87.6	1,024
Infusion	10.1	118
Hysterotomy	0.9	10
Hysterectomy	1.5	17
Totals	100.1	1,169

While 88 per cent of abortions performed on Oahu were on women reporting Oahu residence, the number of non-residents obtaining abortions in the state of Hawaii is unknown.

Only 33 (2.9%) of the induced abortions would have been legal under stringent interpretation and adherence to the law proposed in the model penal

code. If the clause on psychological or mental health of the woman is not included, only 1 per cent would have then been legally eligible to have an abortion.

The total number of live births reported from March 13 through July 15 was 6,208. The proportion of abortions to live births was 1,192/6,208 or 1:5.

B. Selected Medical Data on Induced Abortions

Gestation and Procedures—Almost 85 per cent of the 1,169 abortions were done by the 12th week of gestation, but the time of abortion varied by hospital. At hospital #1, about 55 per cent of the women were in the 5-to-8-week gestation period; the other hospitals averaged 40 per cent in the 5-to-8-week gestation period (Figure 2). Either dilation and curettage (D&C) or D&C with suction accounted for 87.6 per cent of the procedures used (Table 2).

Figure 2—Weeks of gestation at time of abortion (Hospital #1 compared to all hospitals)

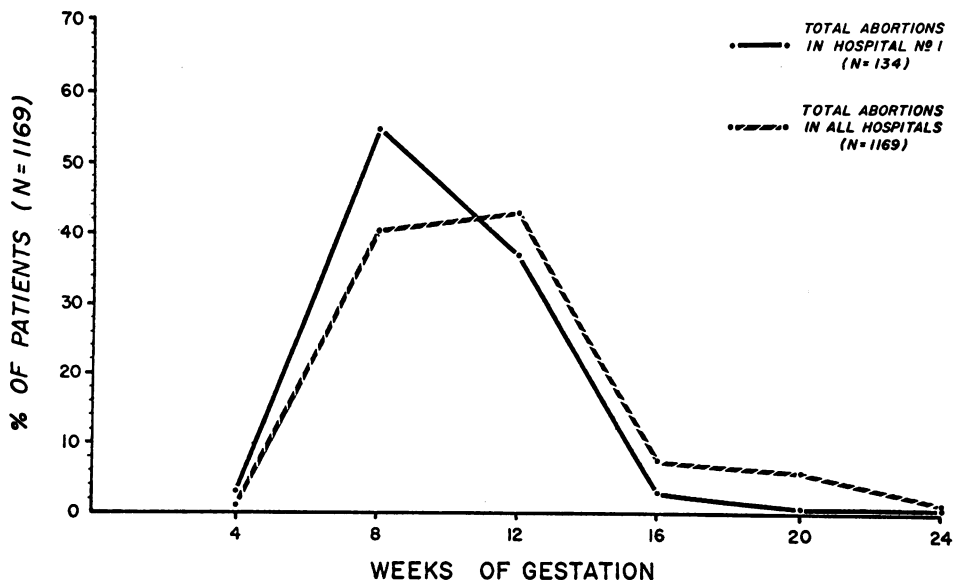


Figure 3—Age distribution of 1,136 induced abortions in Hawaii

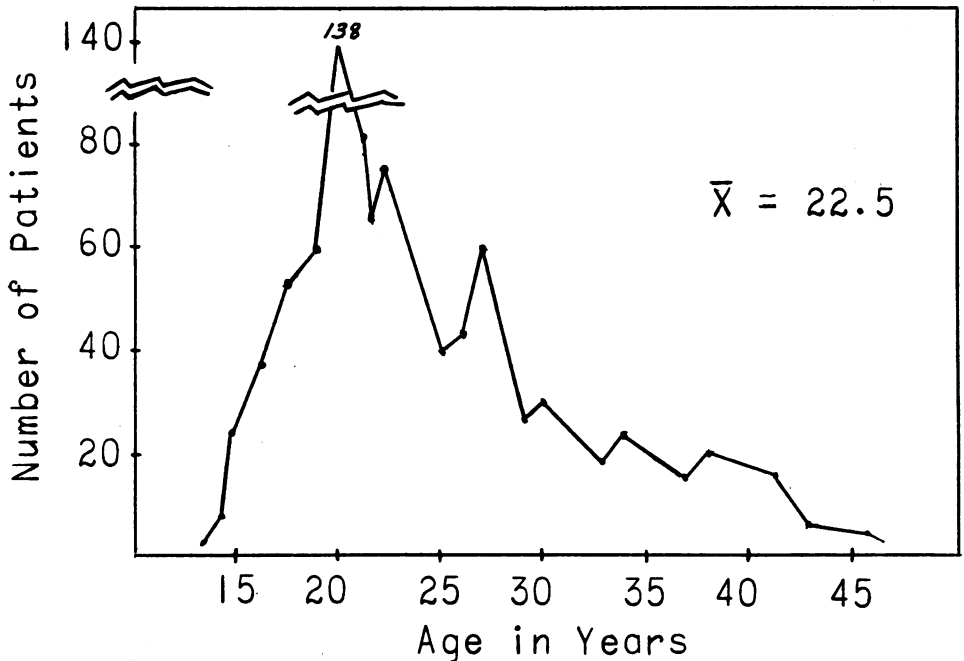


Table 3—Complications by type arising from 1,169 induced abortions, Hawaii 3/13/70-7/15/70

Type	% (4.1%)	No. (N=48)
Cervical laceration	25.0	12
Hemorrhage	22.9	11
Infection	14.6	7
Failed abortion	10.4	5
Uterus perforation	8.3	4
Miscellaneous	8.3	4
Metabolic	6.3	3
Retained placenta	4.2	2
Total	100.0	48

Complications—Gestation—Length of Stay—There were 46 (4.1%) complications out of 1,169 induced abortions reported. Complications are defined to include minor complications, such as cervical laceration as well as major complications which threaten life. Cervical

laceration was most frequent, 12 (25.0%), while metabolic complications, such as pitocin toxicity and hypervolemia, ranked sixth (6.5%) (Table 3).

The percentage of complications by hospital were as follows: Hospital #1 had 0.7 per cent, hospital #2 had 5 per cent, and hospital #4 had 3.2 per cent complications. Incidence of complications in patients in the 8 weeks or less gestation period was 3.2 per cent. In the gestation period between 21 through 24 weeks, there was an incidence of 12.5 per cent. There were no mortalities. Ninety per cent of the reported complications were associated with hysterectomy or hysterotomy; however, hysterectomies (one-third of the time) were treatments arising out of complications or were treatments of choice, with directly related complications (Table 4).

Length of Stay in Hospital—The majority of women (54.5%) stayed five hours or less in hospital #1. In hos-

Table 4—Complications by procedure arising from 1,169 abortions (N=48) Hawaii: 3/13/70-7/15/70

	%
D&C	2
Suction	3
Infusion	5
Hysterectomy	40
Hysterotomy	50

pitals #2 and #4, 11.7 per cent and 16.3 per cent of the patients, respectively, stayed 5 hours or less. In hospital #2, 25.6 per cent; in hospital #4, 20.2 per cent of the women stayed 36 hours or more. In hospital #1, 4 (0.8%) stayed between 18 and 21 hours. None stayed longer than 21 hours.

Costs and Method of Payment—An abortion for patients without insurance coverage of any type cost a minimum of \$300. Most were between \$350 and \$400; however, if a major complication existed, prices might be as high as \$600 or more (Tables 5 and 6). The hospital charges to patients are as noted in Table 6. For patients in the hospital 12 hours or less, and not overnight, the cost was approximately \$160.

The largest percentage of abortions were paid for by individuals (64%). Individual payment may have been by the patient, parent, husband, male responsible for pregnancy other than husband, or a loan. Insurance covered 23.1 per cent of the cases. Welfare (6.9%) and military (4.1%) accounted for the smallest number of abortions. Prepayment plans, major medical carriers, military and welfare covered from 30 per cent to 92 per cent of total costs to patients.

The total number of welfare patients receiving abortions was 81 (6.9%). Of these 65.4 per cent were patients at a single hospital (#2) in Honolulu. Of the welfare patients 4.9 per cent were

residents of the outer islands and received their abortion in a hospital on one of the outer islands.

Distribution of Physicians—Abortions were being performed by 61 physicians on Oahu and fewer than 10 on the 6 outer islands. The number of abortions performed per physician varied from 1 to 110, and 23 per cent of all abortions were done by 3 physicians while 60 per cent were performed by 15.

Results (Demographic)

The medical data reported above were based on 1,169 induced abortions, including 33 pregnancy terminations with medical or psychosocial indications which would have met the prevailing requirements for therapeutic abortion under the old law. These 33 cases have been omitted from the following statistics in order to provide a demographic description of the population actively seeking abortion under the new law.

The age distribution of the first 1,136 induced abortion patients covers a wide range of fertile years. The youngest abortion patient was 13 years old and

Table 5—Range of fees among study participants

Physicians	\$150-\$200
Laboratory fees	\$ 25-\$ 32
Psychiatric nurse consultations	\$ 6-\$ 12

Table 6—Hospital charges and length of stay

Hospital No.	In-out		12 hr-24 hr	
	Member	Nonmember	Member	Nonmember
1	\$135	\$270	\$160	\$320
2	\$150		\$175	
4	\$150		\$150	

Figure 4—Per cent of abortion patients single at time of conception, by ethnic group

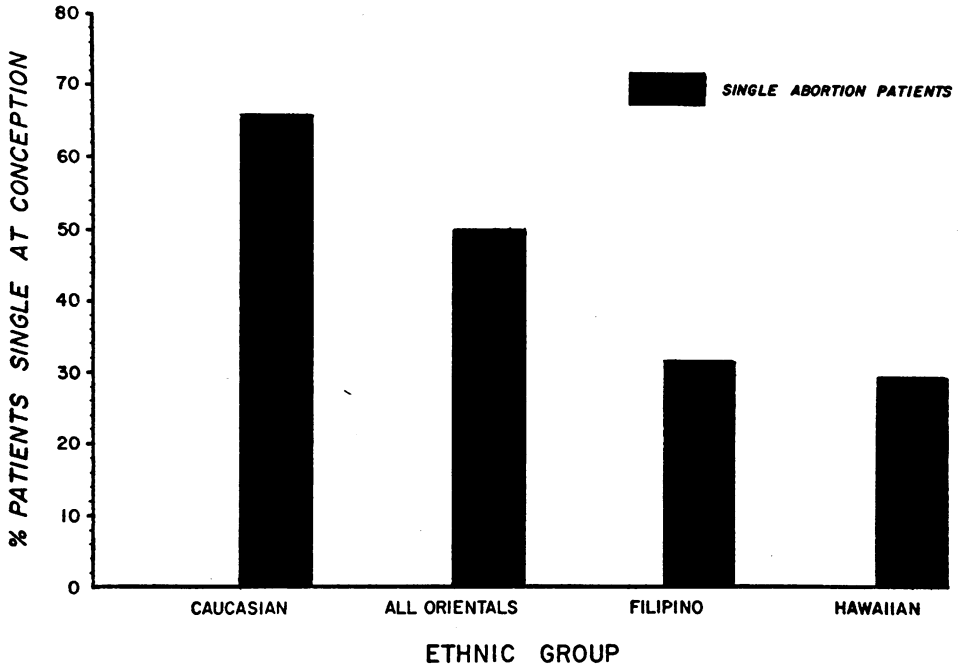


Table 7—Religious distribution of 1,136 abortion patients compared with state of Hawaii total population

	Protestant %	Catholic %	Buddhist %	Jewish %	Other %
Abortion patients	42	28	7	1	22
State distribution*	44	27	14	1	14

* Statistical abstract of sample survey 1962, Economic Research Center, University of Hawaii.

the oldest was 46. Abortions were performed most often on women in their late teens and early twenties (Figure 3).

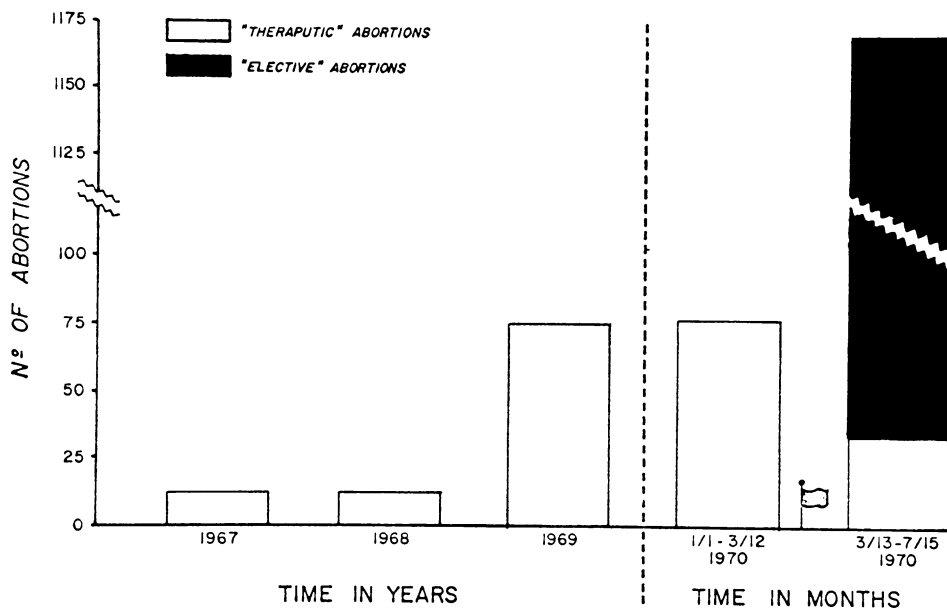
More than half of the abortion patients—623—were terminating a first pregnancy. An additional 265 (23%) were terminating a second or third pregnancy, while the remaining 248 (21%) ended a fourth or higher pregnancy, of which 67 (5%) were the woman's seventh pregnancy or higher.

The data below are from the question-

naire sample of 272 abortion patients at hospitals #1 and #2. This represents 87 per cent of the abortion population at those two facilities during the period of questionnaire administration.*

* Tabulation of the demographic data from hospital charts for those who refuse the questionnaire, reveals no major differences between respondents and nonrespondents in the abortion population. Those who were inadvertently missed in the questionnaire administration likewise appear to be random selection.

Figure 5—Induced abortions: Number of “therapeutic” abortions compared to “elective” abortions



Forty-two per cent of the abortion patients were Protestant, 28 per cent were Catholic, and 7 per cent were Buddhist. These figures are remarkably close to a 1962 survey of religions in Hawaii, except for an under-representation of Buddhists (Table 7). In terms of occupation, 25 per cent indicated they were students, 21 per cent were in clerical occupations, and 19 per cent were housewives (Table 8).

An age breakdown of those in the student category revealed that roughly a third (32.5%) were under the age of 18, i.e., most likely high school students. The age group of students from 18 to 22 accounted for over half (55%) of the student abortion patients.

Abortion patients were slightly underrepresented in the middle income groups and slightly overrepresented in the lower economic brackets compared to total state economic distribution (Table 9).

The most frequently cited reason for abortion in the sample was “I am not married,” which was the primary reason given by over a quarter of the patients (26%). Other frequently given primary reasons were: “I cannot afford to have

Table 8—Occupational distribution of 1,136 abortion patients

Occupation	No.	%
Student	285	25.1
Clerical	241	21.2
Housewife	222	19.5
Prof./Tech.	115	10.1
Waitress, etc.	98	8.8
Business Mgr.	13	1.1
Factory worker	13	1.1
Military/Unknown	149	13.1
Total	1,136	100.0

Table 9—Income distribution of 1,136 abortion patients compared with state of Hawaii total population

	Under \$6,000	\$6,000– 9,999	\$10,000 and above
Abortion patients	37.3%	28.7%	33.8%
State of Hawaii*	34.5%	32.3%	32.6%

* State of Hawaii Data Book, Table 74, "Income of Families and Unrelated Individuals for Oahu, 1964-1967 and Neighbor Islands, 1967," p. 67.

a child at this time" (18%); "I have enough children already" (8.8%); and "A child would interfere with my education" (8.4%) (Table 10).

Slightly more than half of the abortion patients were single (57.5%); 32.4 per cent were married; and 9.1 per cent separated, divorced, or widowed.

The ethnic distribution of abortion patients varied considerably from the state distribution of ethnic groups.* Caucasians, the most overrepresented, comprise 29.8 per cent of the state population and 47 per cent of the abortion population. Japanese comprise 29.8 per cent of the state population, but are underrepresented in the abortion population (18.1%). Hawaiians and part-Hawaiians are also underrepresented in the abortion population (3.3%), but account for 18.5 per cent of the state population (Table 11).

At the time of conception, 65.4 per cent of the Caucasians and 50 per cent of the Orientals were unmarried. By contrast, only about 30 per cent of the Filipino and Hawaiian patients were unmarried at conception (Figure 4).

* Data from 1970 State of Hawaii Data Book, Table 6, "Ethnic Stock of the Population for Hawaii, 1940-1968," p. 13. Data from the 1970 census indicate that Caucasians now comprise a larger per cent of the state population, but parallel breakdowns are not available for the relevant ethnic groups in Hawaii.

Discussion

Approximately 81 per cent of women in Hawaii in the 15-49 age group live on Oahu.* However, out of the total 1,169 abortions during the period under study, almost all abortions were performed in hospitals on Oahu. Since the number of abortions performed per month in Hawaii so far has varied only slightly, no "backlog" appears to have existed. The average number of abortions per day (9.6) as well as the live-birth ratio, are both consistent with the projections made by Smith in 1970 before the passage of the law.†

There were 61 (5.1%) women coming from the outer islands to Honolulu for abortions. This represents the interplay of several factors that might influence a woman, such as social or religious stigmata, desire for anonymity, the attitudes of physicians toward abortion, and availability and acceptability of services in the predominantly rural outer islands.

The actual number of abortions that have been performed on nonresidents is unknown. A small number (33) indi-

* Data from Hawaii Department of Health.

† Changing Hawaii's Abortion Law. Pacific Health Vol. III, 1970.

Table 10—Most frequently given reasons for abortion

	No.	%
"I am not married"	73	26.8
"I can't afford a child at this time"	49	18.0
"I have enough children already"	24	8.8
"A child would interfere with my education"	23	8.5
Other reason given	91	33.5
No reason given	12	4.4
Total	272	100.0

Table 11—Ethnic distribution of 1,136 abortion patients, compared with state of Hawaii total population

	Caucasian	Japanese	Filipino	Chinese	Hawaiian and part Hawaiian	Other including mixtures
Abortion patients	47%	18.8%	5.9%	3.6%	3.3%	22.0%
State* distribution	28.4%	29.8%	8.0%	5.4%	18.5%	10.0%

* 1970 State of Hawaii Data Book, Table 6, "Ethnic Stock of the Population for Hawaii: 1940-1968," p. 13.

cated that they were nonresidents. There has been no obvious rush to the islands by nonresidents in search of abortion, despite the fears voiced by legislators and other concerned citizens before the passage of the law.

It is impossible to state the number of physicians who are qualified to perform diagnostic D&C's or other OB/GYN procedures, but who are refusing to perform abortions. Hospitals determine whether an M.D. is qualified (general practitioner, obstetrician, or surgeon). On Oahu 61 physicians were performing abortions and fewer than 10 on the 6 outer islands. Considering population distribution on the islands, this appears to make services unequally available. Tentative examination of data from the outer islands suggests a trend toward increased numbers of abortions. Whether this will reduce the number of patients coming to Honolulu remains to be seen.

The data indicate that women may have abortions via D&C's on an in-and-out basis (five hours or less) without an increase in complications. Of the three major hospitals, notably patients from hospital #1 were routinely handled at around eight-weeks' gestation, and the complication rate was lowest. The picture from hospitals #2 and #4 is much less clear on this point because of the broad variation of medical practice, the marked differences in length of gestation, and the number of

complications (5.0% and 3.2%, respectively). The average length of gestation was longer (from 10 to 12 weeks) and the average length of stay was much longer in both hospitals, compared to hospital #1. When the average length of gestation increased, as in hospitals #2 and #4, the percentage of complications increased and also the costs. Yet some hospitals (hospitals #3 and #5) keep patients three days, when the gestation is short (12 weeks and under) and the procedure is without complications. Thus an abortion in some instances becomes more expensive than necessary, both in time and money.

Less than one-third (23.1%) of the abortion patients were covered by insurance. (It is interesting to note that approximately two-thirds of the maternities during the same period of time were covered by insurance.) The pre-paid insurance plan will cover hospital costs for "therapeutic" abortions only, not elective. The physician's fee is covered in either instance. The incidence of "therapeutic" abortions at hospital #1 is 2.2 per cent. This is essentially unchanged from the 1967-1968 incidence which indicates that physicians are not classifying abortions as "therapeutic" in order to reduce costs to patients.

Insurance coverage for abortions is based on the criteria for maternity coverage, one of which is marital status. If abortions are to become equally available to all women, then insurance car-

riers for major medical coverage must include such coverage in policies for single women.

Even with this coverage, a substantial segment of women without insurance, and ineligible for Department of Social Services assistance, might be unable to afford \$300—the absolute minimum for an abortion in Hawaii. Women in the medically indigent category may still find it difficult to obtain the necessary services. It is demonstrated in these data that financial factors are considered in making the decision of whether to terminate the pregnancy. However, the lack of money may well influence the decision to continue the unwanted pregnancy. A few private, nonprofit groups make limited funds available, and one group is setting up a loan service to assist such women.

Other possible ways to make abortions equally accessible relate to ways hospitals and physicians can reduce costs. Some of these include treating patients administratively as outpatients. The involved admission procedures are time-consuming and expensive, and could be markedly decreased if the patient were not admitted as an inpatient and assigned a room. The procedure in hospital #1 is for the patient to go to the emergency room, to the operating room, to the recovery room, back to the emergency room, and then to be discharged. The number of beds used by abortion patients in rooms and wards is thus minimal. Primarily, they are used for women with late gestation and/or complications. Another way of reducing costs is to plan the OR schedule for blocks of time for abortions, with one physician doing several in sequence so that professional personnel time, including that of the physician, may be efficiently utilized.

As was to be expected, there was an over-all increase in complications with increase in length of gestation. However, the progression of frequency of com-

plications in relation to length of gestation is not smooth if all complications, regardless of degree of severity, are considered. The 5-to-8-week period has a higher rate of complication than patients in the 9-to-12-week period (Table 12), but these differences are not significant. Eleven or 33 per cent were "miscellaneous," most of them cervical lacerations. It should also be pointed out that more than half of the females were young nulliparas, the category most likely to offer more difficulty in mechanical dilatation of the cervix.

In the group of 13-to-16 weeks of gestation, some patients were treated by D&C/suction and others by infusion, hysterotomy, or hysterectomy. These were scattered throughout the four-week period. This higher frequency of complications than in the 17-to-20-week group may be related to lack of standardized medical-surgical approach to patient management during this period.

Whether women make the decision to have an abortion early in pregnancy is dependent on many complex factors. Our data provide certain clues as to some of them. The reasons most often cited by abortion patients as the major cause of terminating their pregnancies were being single, lacking money, being in school, having enough children, and being too young. The demographic and

Table 12—Complications from induced abortions by length of gestation, Hawaii: 3/13/70-7/15/70

Gestation (weeks)	No.	% Complications
5-8	480	3.2
9-12	506	2.4
13-16	91	9.9
17-20	70	8.5
21-24	16	12.5
Unknown	6	00.0

social data of the abortion patients reflect these conditions.

Almost half of the abortion patients reported current employment. It can be assumed that students, unless employed in some other type of work, would not report themselves as employed. This would mean that probably well over half were actively involved in and committed to a formal activity outside the home. Financial reasons for abortion are indicated by the income distribution comparisons; these show a higher proportion of abortion patients in the lower-income brackets than the state average.

The high proportion of patients giving the reason "I'm not married" for having an abortion, indicates that these women either were unable to marry, or refused to allow pregnancy to become the reason for marriage. At the same time, they also refused the alternative of bearing a child out of wedlock. The large number giving "interference with education" as a reason for abortion sheds more light on their decision not to bear a child, either legitimately or illegitimately.

Abortion is used by all religious groups in Hawaii in close proportion to the size of the group in the state population.* The ethnic distribution of abortions does not match the proportions of those groups within the state, but all ethnic groups in the state are represented. Various ethnic groups tend to utilize abortion to control different aspects of their reproductive life. Among Caucasians and Orientals, abortion tends to be used by single women in a first or second pregnancy. Hence, abortion is used by younger women to postpone the onset of child-bearing and child-rearing. By contrast, among Filipino and Hawaiian women, abortion tends to be used by married women in a third or higher numbered pregnancy. These women appear to be using

* With an underrepresentation of Buddhists, as noted above.

abortion to control the termination of their reproductive lives.

Twelve therapeutic abortions were performed in 1967, and 12 were performed in 1968. In 1969, more than 75 were done—an increase greater than sixfold without any change in the law. In January, February, and the first 12 days of March, 1970, just prior to the change in the law, the incidence of "therapeutic" abortions rose even more dramatically. The number performed during this period equaled the total for 1969 (Figure 5).

The term "therapeutic abortion" had been used to give physicians and patients a means of reconciling the inconsistencies of the law and medical practice, as well as the individual's desire to plan her own reproductive life. Currently, the term "therapeutic abortion" has no consistent usage, particularly since the liberalization and repeal of abortion laws. On one hand, all abortions are therapeutic, either medically, psychologically, or economically. On the other, if an abortion is an "elective" or "voluntary" interruption of pregnancy, it is not considered therapeutic by some. Many phrases and terms are currently in use, such as voluntary interruption of pregnancy (V.I.P.) and intentional termination of pregnancy (I.T.O.P.). In the collection of data, some difficulty was experienced due to differences in terminology and classification. To avoid further confusion, standardized classifications and nomenclature need to be adopted. Medically, all abortions are either spontaneous or induced. Appropriate subheadings could be generated for each category which would serve to delineate the circumstances that surround abortions. Such a method of classification would be simple, workable, and accurate.

There is as yet no clear indication whether the advent of "legal" abortions is affecting the birth rate, marriage rate, and adoption rates. Each abortion, re-

ardless of length of gestation, is reportable as a fetal death to the health department. Consequently, there has been a marked rise in fetal death rates. There was a fourfold increase in fetal deaths reported in one month. However, not all hospitals reliably report fetal deaths due to induced abortions. As an instrument for helping to assess a community's health, the fetal death rate—generally as part of the perinatal mortality and fetal wastage continuum—becomes useless. Health departments need to take the leadership and set up specific guidelines for reporting abortions and fetal deaths as abortion laws change. A redefinition of fetal deaths and a careful review of their significance seem indicated. We suggest any new definition of fetal death specifically exclude induced abortions.

Conclusion

The first 124 days of "legalized" abortion in Hawaii have gone relatively smoothly with little negative reaction from the community; hospital administration and personnel have adjusted well to the change; few complications and no mortalities have occurred. The concern expressed over the possibility of facilities being overburdened by residents and/or nonresidents seeking abortions appears to be unfounded. The costs of abortion (both hospital and medical) are higher than women in the middle and marginal (medically indigent) income categories might be expected to afford. Means of reducing costs and providing funds to patients are being developed by all concerned.

A change in law does not necessarily mean a change in individuals or the physician's acceptance or utilization of previously illegal procedures. The reluctance of certain physicians to perform abortions is one of the factors indicated by the number of patients referred to Honolulu for abortions from the other islands. However, attitudes of the popu-

lation at large, the medical community, and hospital administrations are changing.

To reduce complications, it seems clearly indicated that programs be directed toward getting women involved in the decision-making process early in gestation, possibly not waiting for even a presumptive diagnosis of pregnancy before inducing endometrial shedding. Such programs would require administrative and medical receptivity to outpatient abortion services and their endorsement by medical insurance carriers. Since this would be safer for the women, easier for the physicians, and less costly for the insurance carriers and patients, the result would not only be good medical care but also good medical economics.

Summary

Abortions were performed on 1,192 women in hospitals in Hawaii from the advent of the new law on March 13, 1970, through July 15, 1970. Of these, 1,169 are the subject of this preliminary report.

The incidence of complications was small (4.1%); no mortalities occurred. The geographic, economic, and occupational distribution is reported. The numbers of M.D.'s performing abortions and their distribution were noted not to represent the population loci of the state.

The ethnic distribution of those requesting abortions does not follow that of the state. Differences were noted in the way ethnic groups used abortion to control reproduction. The religious distribution generally matched that in the state, with the exception that Buddhists were underrepresented. The age of women having abortions spans the reproductive period from menarchy to menopause. However, most were performed on women in their late teens and early twenties; 32.4 per cent were married, 57.5 per cent single. While abortions were generally available throughout the

state, problems relating to costs and accessibility of services do exist. However, these seem solvable.

The need for consistent use of standard nomenclature is stressed. It is suggested that a redefinition of fetal deaths, which specifically excludes induced abortions, is indicated.

An important relationship is noted between length of gestation, complications, and costs. It is suggested that by performing abortions as early as four-weeks gestation and on an outpatient basis, many of the problems that now exist in relation to abortions could be resolved.

ACKNOWLEDGMENT—A sincere "Mahalo" is extended to the state of Hawaii for its far-sightedness in leading the country in abortion reform and for sponsoring this research. Thanks are also due to all the hospital and

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Telephone-Radio Course for Podiatrists

The University of Wisconsin is sponsoring a five-week series of telephone-radio postgraduate podiatry seminars, in cooperation with the Wisconsin State Podiatry Society and the Wisconsin Regional Medical Program. Various hospitals throughout the state have been equipped to handle the telephone-radio lectures, delivered by podiatrists and members of the medical school faculty. Although the course is primarily designed for podiatrists, it is also open to family practitioners, pediatricians, internists, and registered nurses.

(For further information, write: Dr. Kevin P. Kortsch, President, Wisconsin State Podiatry Society, 9122 West Center St., Milwaukee, Wis. 53222.)